HEALTH AND HEALTH SEEKING BEHAVIOUR AMONG THE TRIBALS: A CASE STUDY IN SUNDARGARH DISTRICT OF ODISHA

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CERTIFICATE

This is to certify that **Mr. Saswat Kumar Pradhan** has carried out the research embodied in the present dissertation entitled "**Health and Health Seeking Behaviour Among the Tribals: A Case Study in Sundargarh District of Odisha**" under my supervision for the award of the master degree in Development Studies of the National Institute of Technology, Rourkela. This dissertation is an independent work and does not constitute part of any material submitted for any research degree or diploma here or elsewhere.

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Saswat Kumar Pradhan

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Abstract

The common beliefs, customs and practices connected with health and disease have found to be intimately related with the treatment of disease. The health problems of rural especially of the tribals need special attention because the tribal people have distinctive health problem, which are mainly governed by their traditional beliefs, practices and ecological conditions. Some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo. The present dissertation analyses the socio-economic and cultural onslaughts, arising partly from the erratic exploitation of human and material resources, have endangered the naturally healthy environment. The present study explored the community perspective towards the causes of various diseases prevalent and the health and health seeking behaviour among the tribals. The study was conducted in the Jhirdapali Panchayat of Bonaigarh Block in Sundargarh district in Odisha taking 148 households using random sampling method. Both qualitative and quantitative data was analyzed in the backdrop of the project objectives. Quantitative data was tabulated and statistically analyzed using SPSS software. The study has revealed that the cause of illness and healing system are found to be associated with the magico-religious beliefs and it was also revealed that the factors like age, sex, education of the patient. Types of illness, severity of diseases, health care facility, belief regarding the cause of diseases and previous experiences affects selection of different ways of treatment and finally the study concludes with the relevant finding that the villager's responses towards illness behaviour is guided and conditioned by their culture.

Chapter- I

Introduction

Health is the major pathway to human development, which is the cornerstone for a healthy, wealthy and prosperous life. Health is also a well reflected and self-evident in the proverbial saying "Health is Wealth". There is no magical mechanism, which can bring good health overnight. It is a gradual process, which takes time and hinges on many things. As a multifaceted aspects health has been defined by WHO as "a state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity". The health of an individual or of a community is concerned not only with physical and mental status, but also with social and economic relationship (Chakrabarty 1999). What is consider a being healthy in one society might not be considered healthy in another society (Mishra & Majhi, 2004). Ackernocht (1947) has rightly pointed out: "Disease and its treatment are only in the abstract purely biological process. Actually, such facts as whether a person gets sick at all. What kind of disease he acquires and what kind of treatment he receives depend largely upon social factors". The common trust, customs and practices connected with health and disease have found to be intimately related with the treatment of disease (Majhi et. al, 2004). In order to bring holistic development of a society the cultural dimension of the health of a community should be given importance. The health problems of rural especially of the tribals need special attention because the tribal people have distinctive health problem, which are mainly governed by their traditional beliefs, practices and ecological conditions.

Rural people in India and tribal populations in particular, have their own beliefs and practices regarding health. Some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo (Mishra & Majhi, 2004). They therefore seek remedies through magic & religious practices. On the other hand, some rural people have continued to follow rich, undocumented, traditional medicine systems, in addition to the recognized cultural systems of medicine such ayurveda, unani, siddha and naturopathy, to maintain positive health and to prevent disease. However, the

socioeconomic, cultural and political onslaughts, arising partly from the erratic exploitation of human and material resources, have endangered the naturally healthy environment (e.g. access to healthy and nutritious food, clean air and water, nutritious vegetation, healthy life styles, and advantageous value systems and community harmony). The basic nature of rural health problems is attributed also to lack of health literature and health consciousness, poor maternal and child health services and occupational hazards.

In tribal societies, the system of cure is not only based on magico-religious means but also on treatment with different herbs and plants. Tribal societies have developed their own medicine system and some rudimentary knowledge base of medical techniques including the diagnosis of the disease at individual level. Both these techniques i.e. magico-religious and herbal medicine are used to cure the sick either together or separately. People have knowledge about the plants in their surroundings and also attribute cultural beliefs and practices to the plants.

1.1 Review of Literature

In developing countries, women are high risk for several reproductive health problems especially reproductive tract infection/sexual transmitted infection (RTI/STI). These problems arise primarily as a result of early marriage, high fertility, higher number of pregnancy and unsafe sex. Reproductive morbidity is an important public health issue as well as social problem. The issues of reproductive and sexual health, in particular RTI/STI, have concerned attention since the International Conference on Population and Development (ICPD) held at Cairo in 1994. Many developing countries have paid more attention on reproductive health service to all the population. In India, the Reproductive and Child Health (RCH) programme that was introduced in 1997, through the network of health centers all over the nation, has addressed the matter of reproductive health directly which was largely ignored by the public health services earlier. Reproductive morbidity refers to the diseases that affect the reproductive system, although not necessarily as a consequence of reproduction. Reproductive morbidity can be classified into three categories: obstetric morbidity, gynecological morbidity and contraceptive morbidity.

This study mainly focuses on gynecological morbidity especially RTI. Gynecological morbidity is defined as any condition, disease or dysfunction of the reproductive system, which is not related to pregnancy, abortion or childbirth, but it may be related to sexual behaviour (WHO, 1990).

In rural areas, the lack of awareness and health facilities in turn lead to a high incidence of STDs/RTIs. The prevalence of Sexually Transmitted Diseases (STDs)/ Reproductive Tract Infections (RTIs) is much higher among women than among men, in India, but with regard to treatment-seeking the situation is just the opposite-far fewer women seeking treatment, than do men. However in spite of the availability of low cost and appropriate technologies to manage STDs/RTIs in the primary health care setting most of the sexually transmitted infections remain hidden and unrecorded and a very small proportion of people (5-10%) suffering from the disease attend government health facilities. There have been relatively few studies on health care seeking behaviour in relation to Sexually Transmitted Diseases (STDs) and Reproductive Tract Infections (RTIs) of women in rural areas (Singh et al, 2012)

The main contribution of the study is to add a dynamic perspective in analyzing individual's health seeking behaviour. Overall, the empirical evidence suggests that agents are biased towards one type of health care and they don't switch caregivers even if the treatment has failed to heal them. Patients behave without taking into account the private information on their health status. The paper also investigates how the choice between a formal health care provider (hospitals, health centre, dispensaries, clinics) and an informal one (pharmacy, practitioner's home, family homes, self-care or no-care) changes with individual and household characteristics. The main cost associated to the formal health sector is the distance between the household and the facility, while education positively affects the likelihood to have formal therapies. All the estimates are controlled for types of symptoms and diseases. These results shed light on a relevant problem in Tanzania and they have important implications from a policy prospective. The individual health conditions are not only driven by the generally inefficient supply side of the health market, but even from the interesting structure of patient's demand. The

success of a therapy is not an important factor involved in the choice of a specific caregiver. This feature fosters the existence of low quality and not qualified doctors and health services. The first step to enforce the demand for formal care is to promote education and to disseminate informative campaigns to overcome cultural bias towards informal caregivers. Second, a more capillary distribution of government-run health services is necessary. This is a very costly and long-term solution, anyway. An alternative response could be the promotion of groups of official doctors in charge of visiting sick poor households in rural area from time to time (Carno, 2008)

As the medical systems of any society are cultural derivatives, the traditional health care system of tribal groups persists long before western innovations in health care are implemented (Mahapatra, 1994). Tribal people differ from other communities by virtue of cultural settings. Their health care problems stem from illiteracy, poor infrastructure, and poor sanitation and also, from some customs and traditions peculiar to these groups (Gigoo et al, 2009). In most tribal communities, there is a wealth of myths related to health. Health and treatment are closely inter related with the environment, mostly the forest ecology. Many tribal groups use different parts of a plant, not only for the treatment of diseases, but for population control as well (Chaudhuri, 1990)

The tribal people give importance to find out the cause of illness rather than the cure. After ascertaining the cause of illness the go for proper treatment practice. It is seen that the cause of illness and healing system are found to be very much associated with the magico-religious beliefs (Mishra et al, 2001).Another study among the Meitis of Manipur reveals that though the people are educated enough, the concept of deities and their effect on human health are widely prevalent among them (Sunita Devi, 2003).While studying on the causes of underutilisation of Biomedicines among the tribal women of Rajasthan Bhasin reveals that their cultural attributes are attached to the concept of health and diseases (2004).The popular belief that most diseases occur due to supernatural powers led to the concept of seeking relief through jadoo (magic), keeping the modern medical practitioners as a last resort (Sumathy, 1990).

The concept of health seeking behaviour showed the complexity of the tribal medical system in Arkura valley. The cause of illness and healing system are found to be related with magico-religious beliefs. Along with herbal treatment, magico-religious practices are still occupying a significant position in their indigenous method of treatment. In the process of decision making process father plays a dominant role as a head of the household. Though, mother take the decision in the absence of counter person but the dominance of male in the case of health seeking is still prevailing. The factor like sex, education, age of the patient and types of diseases, previous experiences effect on the selection of different path of treatment (Sharma et al, 2001.).

While studying on health and health seeking behaviour among tribal communities in Kandhamal district, Odisha Mishra and Mishra reveals that, the etiology of malaria and its healing system are found to be associated with the magico-religious beliefs. Along with herbal treatment, magico-religious practices are still occupying a significant position in their indigenous method of treatment. The educated people are more exposed to the modern medical system in the case of malaria and other disease. Tribal people prefer the traditional method of treatment, which is available near to their door. The various socio economic factors such as age, sex, educational qualification, economic condition of the patient, beliefs the practices, etc. have more or less influenced the health seeking behaviour (2006).

The health seeking behaviour of tribal people is based on the processes by which tribal recognizes sickness and the ways to counteract it. Illnesses are constructs of belief and knowledge, which vary with time and space. In tribal societies, the system of cure is not only based on magico-religious means but also on treatment with different herbs and plants. Tribal societies have developed their own medicine system and some simple knowledge base of medical techniques including the diagnosis of the disease at individual level. Tribal people use both magico-religious and herbal medicine for their treatment (Praharaj, 2011). While working on Bhuyan and Kharia of Jharkhand Balgir said that health is a function not only of medical care, but also of the overall integrated development of society: cultural, economic, educational, social and political society.

Each of these aspects influences the health status and quality of life. (2010). The 'quick therapy' is considered as a part and parcel of allopathic system among tribals. However, for any kind of illness, Bhattara women used home remedy on priority basis. It was also observed that tribal women were not against the use of modern allopathic treatment in spite of the prevalence of the extensive use of traditional treatment (Mohapatra and Kalla, 2000). The rapid depletion of natural surrounding and eco-system of tribal people compounded with infiltration and intrusion of non-tribal elements into tribal domain play a major role in changing tribal ethos, value system and their worldview. The traditional health care system still finds its meaning of survival in tribal domain. The traditional medicines, healers and the priests can still relate a link between men, nature and the super-natural beings. This is the link on which the uniqueness of tribal society exists. The tribal people feel at home with the safety given by their traditional healers against psycho-social problems or spiritual insecurity (Praharaj, 2009). Bhasin finds that in case of serious illness people tend to attend modern health care services. But in many cases accessibility of such facilities do not confirm people's recognition of modern health care system. People regularly believe in spirit and other supernatural beings as causes of disease and priority of treatment inclined mostly towards traditional healers (2004). Tribal people live in forests and depend completely on the land and forest for their daily needs. Hence, for their medical problems, they prefer to be treated by the vaidraj or vaidya (traditional healer) with traditional medicine, which basically uses extracts from herbs found in the forests. Due to their easy accessibility and availability, these healers wield important influence over the health seeking behaviour of the tribal groups (Gigoo et al, 2009).

When a person shows unusual symptoms and changes in behaviour and becomes weak slowly in spite of other curative measures, the people believe that she/he is affected with the evil spirit. The medicine man possesses innate powers and based on the symptoms identified, particular ancestor of a spirit is considered responsible for the ill health of the person. Then he follows a process to get in to trance to identify the dead ancestor. That procedure requires materials like '*korra*' flour, *Sindur*, turmeric power, sambaing, eggs and different types of fruits and flowers. He also tones some mantras. If the patient dies

in spite of the shaman's efforts, the blame is passed on only to the powerful evil spirits, but not to the shaman (Palkumar et al, 2006).

The study of tribal health should be with reference to their distinctive notions regarding different aspects of diseases, health, food, human anatomy and faiths as well as in the process of interaction with modern world (Choudhury, 1994 and Lewis, 1958).

1.2 Statement of the Problem

The literature available reflects that there are no much studies conducted on socio-cultural perspectives of health and illness. There are very less studies held on tribal health especially in the case of Western Odisha. The earlier studies have given more emphasis on particular aspects like health, economic status where as present study will give more emphasis on socio-cultural aspects in Sundargarh district of Western Odisha.

1.3 Objective of the study

i. To find out the community perspective towards the causes of various diseases prevalent in the study area.
ii. To understand the health and health seeking behaviour among the tribals in the study area.

1.4 Conceptual Framework

While doing study it will reflect upon the various aspects of diseases and Health seeking behaviour. It will develop a link among various factors like peoples need, socio-cultural, economic and gender aspects.

1.5 Research Methodology

1.5.1 Universe of the Study

Using the purposive sampling method the Jhirdapali Panchayat of Bonaigarh Block in Sundargarh district was selected to carry out the study. As Sundargarh District falls under Fifth Schedule Area and more than 50% populations are tribal and their living condition

is not much developed, it helps us in understanding their health problem. Bonai is one of the tribal dominated sub-division in this district where more than 70% people are belonging to tribal communities. Here tribal communities like Gond, Kishan, Kolha, Bhuiya and Mundas are found.

1.5.2 Sampling Procedure

Using systematic circular random sampling method, 7 villages such are Basudihi, Chandrapur, Jhirdapali, Mardhi, Chikatnali, Tuniapali and Nuagao selected.

1.5.3 Sample Size

In consultation with officials, NGOs, medical practitioners Jhirdapali panchayat was selected for the final study. This panchayat is having 9 villages. Out of these 9 villages we had selected 7 villages randomly. Using systematic circular random sampling method 148 households were selected.

1.5.4 Source of Data

Data was collected both from primary and secondary sources. Secondary data was collected from books, journals and Govt. Records. Primary data was collected from field using household schedules, case study methods, interviews and participant observation method. Some interactions were held with officials from local health centers, medicine practitioner, tribal priest, local shamans, and tribal medicine man. Few PRA techniques were use to gather the information from village.

1. 5.5 Data Analysis

Both qualitative and quantitative data was analyzed in the backdrop of the project objectives. Quantitative data was tabulated and statistically analyzed using SPSS software. Qualitative data was interpreted based on the information collected from the field.

1.6 Significance of the Study

Health is a social aspect rather than an economic one. Understanding the societal customs, traditions and beliefs that guide the economic activities of health seeking behaviours help us in finding the factors that guides their health seeking behaviours. It help us to understand the significance of traditional methods of treatment in contemporary India.

1.7 Chapterization

The first chapter deals with the introduction and literature review. It explains about the Health seeking behaviour among tribals. It also discussed the objective and methodology of the project. The second chapter deals with the village profile in the study are. The third chapter deals with the impact of Health, Illness and Etiology, fourth chapter deals with Health Seeking Behaviour. The last chapter provides a brief summery and conclusion.

Chapter- II

Profile of the Study Area

2.1. Introduction to Odisha

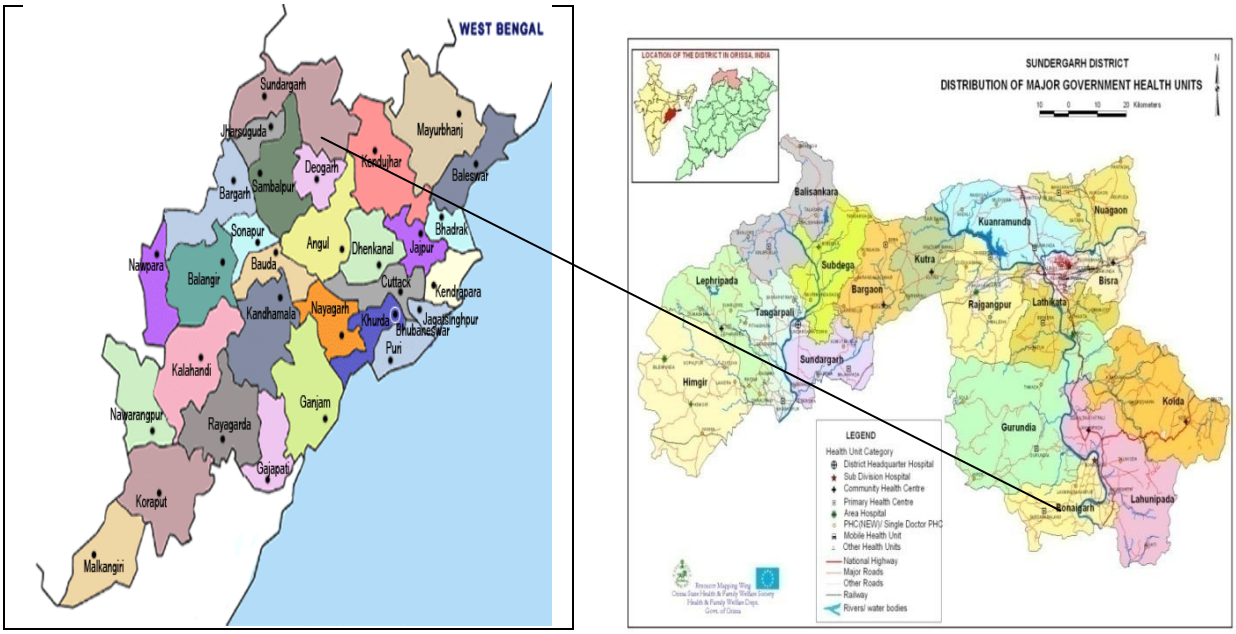
Odisha is a major state in eastern India with an estimated population of 35 million people. The annual population growth is 1.83 per cent, which is lower than the all-India figure of 2.14. Scheduled Tribes and Scheduled Castes, mostly living below the poverty line, constitute nearly 41 per cent of the population. Approximately half of the state's people live below the poverty line, with limited access to exploitable resources due to a complex interplay of social, economic, and cultural dynamics. Frequent droughts, floods, and other natural calamities not only impoverish the people, but also make them morbidly stoic towards the pace of development. Despite some attempts by successive political leadership, fairness in resource distribution has evaded the disadvantaged groups. The inability of these groups to demand their own rights has not improved the situation.

The disease burden is high. Communicable, pregnancy-related, and childhood ailments account for about 65 per cent of the diseases. The infant mortality rate is 97 (Sample Registration System 1999), the highest in the country. The publicly provided health service outlets are available, more or less in accordance with the all-India norms, but factors such as low population density (2003), geographic inaccessibility, cultural barriers, ignorance, poor service quality, and the deep-rooted influence of traditional healers make the overall outcome of service systems unsatisfactory.

The economy of the state is weak. The agriculture sector, employing 64 per cent of the total workforce, contributes 35 per cent to the State Domestic Product. Trade, mining, and community services have shown modest growth in the last decade. Unemployment is high, and the seasonal nature of agricultural work contributes to under-employment too. The public sector, employing about 5,00,000 people is in proportion to the population, one of the fattest in the country at about 15 government employees per 1000 population. Public finances are not in a satisfactory state, with a heavy debt burden.

Public sector expenditure on health is about 1.2 per cent of the Gross State Domestic Product, and about 3 per cent of the annual budget. A large portion of the funds is spent in the tertiary sector. Allocation to health has remained low during the 1990s, and the sustained increase in the wage and salary component has made the non-salary portion shrink over the years. Coverage of preventive services, particularly immunisation, has been generally satisfactory during the last decade. Medical care is mainly publicly provided (90 per cent), and the organised private sector is very thin.

Prior to the establishment of allopathic hospitals in the late nineteenth century, people generally had either no access or were reluctant to accept modern medical systems due to educational backwardness and blind beliefs regarding infectious diseases. Witchcraft and sorcery were rampant. However, ayurveda played a vital role in more systematic treatment at that time. A network of hospitals and dispensaries doing primarily curative work using modern medicine existed before Independence. The hospitals were under the district boards. The growth of modern medical institutions in a more widespread manner, and the increasing faith of the people in modern systems happened insidiously after Independence. State patronage for modern medicine, ayurveda and homoeopathy continued post 1947 (Gupta, 2002).



2.2. Brief description of the Sundargarh District

Sundargarh district was constituted on the 1st January, 1948 out of the two ex-States of Gangpur and Bonai, which merged with Odisha on that day. True to its name, this "beautiful"district of Sundargarh with about 43% of its total area under forest cover and numerous colorful tribes marking its landscape and with abundant mining potential is bounded by Ranchi District of Jharkhand on the North, Raigarh district of Chhatisgarh on the west and North-West, Jharsuguda, Sambalpur and Angul District of Odisha on the South and South-East and Singhbhum District of Jharkhand and Keonjhar District of Odisha on the east (Odisha Government Website).

Geographically the district is not a compact unit and consists to widely dissimilar tracts of expansive and fairly open country dotted with tree-clad isolated peaks, vast inaccessible forests, extensive river valleys and mountainous terrain. Broadly speaking, it is an undulating tableland of different elevations broken up by rugged hill ranges and cut up by torrential hill streams and the rivers IB and Brahmani. The general slope of the district is from North to South. Because of this undulating, hilly and sloping nature of landscape, the area is subject to rapid runoff leading not only to soil erosion but also to scarcity of water for both agriculture and drinking purpose.

2.3. Study Area Profile

Total population of Sundargarh district is 2,080,664, where female population is 1,024,941 and male population is 1,055,723. Literacy rate is 74.13 %, where female is 65.93% and male is 82.13% (Census, 2011). If we reflect on the health care facilities of this district it reflects that there are 30 dispensaries, 85 medical institution,1 district headquarters hospital, 2 Sub-Divisional hospital , 10 primary health centers.

The study was carried out in Jhirdaplai, Tuniapali, Basudihi, Chandrapur, Chikatnali, Mardhi and Nuagao of Jhirdapali panchayat, Bonaigarh block of Sundergarh district. All the study villages fall under fifth schedule area. The tribal communities like Bhuyans (Both Poudi & Plain), Munda, Kisan, Oraon, Kolha, Gond, Mundari, Kharia, Bhumij etc.,

found in this panchayat. Most of these tribal communities depend on cultivation for their survival. Around 148 households were selected for the study.

2.3.1. Demographic Profile of the Study Area

The demographic profile of the study area represents the numerical strength of different communities. It also shows the percentage of males and females in the respective villages and communities (Table No. 2.1).

Table No.2.1: Communities by village and Gender

Village Name	Tribe											
	Munda		Gond		Kisan		Bhumij		Oraon		Total	
	M	F	M	F	M	F	M	F	M	F	M	F
Jhirdaplai	1	1	8	10	0	0	0	0	0	0	9	11
Basudihi	13	2	3	0	3	2	13	1	1	0	33	5
Chandrapur	0	0	16	8	2	1	1	0	0	0	19	9
Mardhi	0	0	6	4	3	2	0	0	0	0	9	6
Nuagao	1	0	0	0	2	0	0	0	0	0	3	0
Tuniapali	0	0	3	0	12	3	0	0	0	0	15	3
Chikatnali	0	0	3	1	3	1	0	0	13	5	19	7
Total	15	3	39	23	25	9	14	1	14	5	107	41

Source: Survey Data

The table above reflects that around 27.7% households are female dominated. While the highest female-headed households were observed among the Gond tribe, the lowest was observed among Munda.

The total population of the village is 643. 49% population is female. Highest percentage of people (24.57%) in the study area belongs to the age group of 15-25 (Table No. 2.2).

Table No. 2.2: Population Distribution by Age and Sex

Age group	No. of male	No. of female	Total
0-5	28	31	59
5-15	58	63	121
15-25	78	80	158
25-40	65	63	128
40-60	48	47	95
60 and Above	51	31	82
Total	328	315	643

Source: Survey Data

49% population is female. Highest percentage of people (24.57%) in the study area belongs to the age group of 15-25.

2.3.2. Ethnic Composition

There are various tribal communities like Bhuyan, Munda, Kisan, Oraon, Gond, Mundari, Kolha, Kharia, Bhumij etc., are inhabiting in the study area. The Bhuyans (Both pori or hill Bhuyans and plain Bhuyans) are said to be the original inhabitants of the area while Kolha, Kisan, Munda, Oraon etc., are the migrants. Among the Bhuyan tribe, Pouri or hill Bhuyans form the majority. Kisan community is consider economically and politically dominant community in this region. However, Gonds are considered as numerically dominated community in this region (Table No.2.1).

2.3.3. Religion and Festivals

In the study area, it was observed that all the households belong to either Hindu or Christian religion. Around 19% households are belonging to Christian religion and the rests are Hindus. Around 40% Christian households belong to Munda community. All most all Gond and Bhumij households belong to Hindu religion (Table No. 2.2). Though they had their own religion but in course of time they culture is being diffused. The tribal communities belonging to Hindu religion are worshiping Lord Siva, Goddess Durga, Tarini and local deity Goddess Bolani. There are four temples and 3 churches existed in the locality. Throughout the year they celebrate lots of festivals as per their own religion and customs. However, all most all the villagers irrespective of their religion used to participate in celebrating Holi and Diwali as community festival. The tradition of animal sacrifice is still prevalent in that locality. They used to celebrate Bolani Maa festival in every two years where all the community and religions participate. During these festivals people used to sacrifice animals as a mark of respect to Goddess Bolani. During field visit it was observed that the tribal communities (Table No. 2.3).

Table No.2.3: Distribution of Religion by Community

Tribe	Hindu	Christian	Total
Munda	7	11	18
Gond	61	1	62
Kisan	26	8	34
Bhumij	14	1	15
Oraon	12	7	19
Total	120	28	148

Source: Survey Data

2.3.4. Economic Organization

Our country's economy is Agrarian economy where 75% of the population depends on Agriculture for their livelihoods.

Agriculture is the primary means of livelihood of the tribal people of this area. 78% of the total workers depend solely on agriculture. They consider it more stable, independent and regular than the allied activities. In view of uneconomic holdings and undulating nature of terrains, productivity is very low. It is a mode of living than an income-earning proposition. The agricultural income of the tribal is not that secure due to the fact that their techniques are elementary. Agriculture is exposed to the vagaries of nature and the modern method of protecting crops against nature's caprices and destruction by insects, pests and wild animals are not known to them. Due to geographical condition and traditional method of cultivation, the average yield is low. Second crop is unthinkable without assured irrigation facility. In the tribal villages, the house-holds live spread apart in hamlets rendering contacts by extension workers difficult. Though all most all the households depend on agriculture for their survival, around 14% households are landless. Most of the land holders belong to marginal farmers (56%). Around 20% households are belonging to medium farmers. Nobody in this village having more than 10 acres of land (Table No. 2.4).

Table No. 2.4: Community Wise Land Holding Size

Tribe Name	Size of Land holding (acres)					
	Land less	Marginal Within 2.5 acres	Small 2.5-5 acres	Medium 5-10 acres	Large Above 10 acres	Total
Munda	2	13	3	……..	……..	18
Gond	11	39	10	2	……..	62
Kisan	4	20	9	1	……..	34
Bhumij	5	10	……..	……..	…….	15
Oraon	…….	15	4	…….		19
	22	97	26	3	--------	148

Source: Survey Data

Though all most all households are suffering from poverty, only 58% households are having BPL card, 12% household having Antyodaya card, 29% households have received Indiara Abaas and 29% households have received Old age pension (Table No. 2.5).

Table No. 2.5: Households Availing the Government Facilities

Govt. Facilities	Yes	No	Total Households
BPL Card	87	61	148
Indira Abas	43	105	148
Antyodaya Scheme	18	130	148
Old age pension	44	104	148

Source: Survey Data

Apart from agriculture all most all the households are depending on forest for their livelihoods. Few households are having poultry. Around 7% households are engaged in non-farm activities after agricultural activities. Only few households depend on service sector (3.2%) and business sector (2.1%) (Table No.2.6).

Table No. 2.6: Main Source of Livelihood

Main Source of Livelihood	Households
service	5 (3.4%)
Own cultivation	78 (52.7%)
farm labour	55 (37%)
Non-farm labour	7 (4.8%)
Business	3 (2.1%)
Total	(100%)

Source: Survey Data

2.3.5. Irrigation

The study area has limited irrigation facilities. Although the rainfall is adequate for a fairly good khariff crop, its erratic distribution often renders the crop risky. The land

surface being undulating, most of the rain water is lost as run off. Many small perennial streams however flow which can be harnessed for Khariff as well as Rabi crops. During the years, attempts have been made to tap rain water through Water harvesting Structures, Diversion weirs but much remains to be done in this regard. Around 93.65% households claim that they are totally depending on rain water for their cultivation. Only one dam is situated there for irrigation. Basudihi dam not much helpful for the farmer, it is not proving sufficient water to the firming land. Only 5.5% farmer were able to utilize this dam water and only .8 farmers use bore well water for irrigation (Table No.2.7).

Table No. 2.7: Source of Irrigation

Source of Irrigation	Households
Canal	7
Well	1
Rain Water	118
Total	126

Source: Survey data

The main crops grown are paddy in the plain land and millets, Nizer on the slopes. Mustard, Castor, till, pulses, maize and other vegetables are grown in small patches close to village habitations. Despite of extension efforts over the past years, the standard of agriculture in the area has not progressed to the desired extent. Generally, long duration varieties of crops are grown in the hope of better yields. Podu (Shifting Cultivation) is still practiced in hill slopes. Very small patches are cropped during Rabi. Although there has been comparatively more use of fertilizer, yet the intake is negligible.

2.3.6. Transport and Communication Facility

Though the study area is adjuring to the NH 23, there are no proper communication facilities to reach at the village. Even there is no proper road to reach at Basudi and Chikatnali village. Whereas the other three village having kacha road. Though Prime

Minister Road Yojana was observed in Jhirdapali village, it is not fully prepared. All most all the households having mobile connections.

2.3.7. Housing Pattern

All most all the households (98%) have kutcha house. People of this area don't have such funds where they can do a well concrete house. Mostly they prefer kutcha houses, which they made it by mud and bricks. During the rainy they face many problems due to this type of house and this can be reason for mosquito's growth (Table No. 2.8).

Table No. 2.8: Types of Households

House Type	Households
Pucca	5 (3.4%)
Semi pucca	19 (13.0%)
Kutcha	98 (66.4%)
Hut	17 (11.6%)
Temporary	9 (5.5%)
Total	148 (100%)

Source: Survey Data

2.3.8. Infrastructure

The study area is having two UP schools and one high school. The children go to Jhirdapali High school for their education. There are two post offices located at the study area. There is no hospital in the Jhirdapali Panchayat. Villagers used to visit S.Balang hospital, which is around 5 KM from study area.

2.3.9. Sanitation

The study area has very less in sanitation facility. Out of 148 households only 2.02% households have bath room with latrine facilities, where as 96.62% households don't have bath room and latrine facilities. The lack of awareness and poor economic situation is the major obstacle for better sanitation (Table No. 2.9). There is no drainage system. Most of the people in the village go for open defecations.

Table No.2.9: Availability of Sanitation

Sanitation Facility	Households
Yes	3 (2.02%)
No	143 (96.62%)
Total	148 (100)

Source: Survey Data

2.3.10. Source of Drinking Water

In the study area most of the villagers depend on the tube well (93.2%), only 0.7% households depend on stream, 2.7% households depend on open well and (3.4%) households depend on pond. Most of households use tube well water because they don't have any other water supply (Table No. 2.10).

Table No. 2.10: Main Source of Drinking Water

Drinking Water Facilities	Households
Tube Well	138 (93.2%)
Open Well	4 (2.7%)
Stream	1(0.7%)
Pond	5 (3.4%)
Total	148 (100%)

Source: Survey Data

2.3.11. Cooking Fuel

The villagers mostly use wood as cooking fuel. They collect fuel wood (86.3%) from nearest forest. Apart from wood they use charcoal (13.7%). The villagers mostly depend on the forest resources for their fuel (Table No. 2.11).

Table No. 2.11: Source of Cooking Fuel

Cooking Fuel	Households
Wood	128 (86.3%)
Charcoal	20 (13.7%)
Total	148 (100%)

Source: Survey Data

2.3.12. Literacy

The level of education of the household members also affects the health seeking behaviour. The education of the head of the household regulates the treatment standard of the patient. The education of the female member in the household also plays a role in the decision making process of the treatment. The level of education is one of the judgment factors of the treatment seeking behaviour. Those who are highly qualified or more literate than others they prefer modern medical treatment and those who are literate or just lower primary mostly prefer traditional health treatment. In below tables it has shown the divisions of literacy level among female and male. Around 33.74% populations in the village are illiterate. While the female literacy rate is around 60% male is 72% (Table No.2.12).

Table No. 2.12: Educational Status

Education Level	Female		Male		Total	
	Percentage	No.	Percentage	No.	Percentage	No.
Illiterate	39.7	125	28	92	33.74	217
Lower Primary	27.9	88	30.2	99	29.08	187
Upper primary	14.3	45	20.1	66	17.26	111
Highschool	5.4	17	4.3	14	4.82	31
Matriculation	8.3	26	9.1	30	8.70	56
Intermediate	4.1	13	5.8	19	4.97	32
Graduation	.3	1	2.4	8	1.39	9
Total	100	315	100	328	100	643

Source: Survey Data

Chapter-III

Health, Illness and Etiology

Health is a common theme in most of the cultures; in fact, all communities have their own concepts of health and illness as part of their culture. Based on their earlier experiences with illness, various training on symptoms, different people of different societies has different conception of health. What is considering as being healthy in one society might not be consider so healthy in another.

Health and illness are two antagonistic concepts; one is defined as the absence of other. Similarly health and illness are two poles of a continuum. It has taken as a bipolar concept. An individual can identified as ill when she/he lacks the condition, which is specified in the definition of health.

Village Chandrapur is near to the S.Balang Community Health Centre (CHC) but people still belief in black magic and prefer local quack for treatment. As per one of the S.Balang CHC staff; people from that region mostly belief on black magic as well as medical treatment. But people giving first preference to local quack & *gunia* treatment. During the field visit it was found that that, most of the villagers are not accessing the modern health care system. Dependency on quack and local medicine man is very high.

3.1. Perception of Health and Illness

Illness perception on the one hand and treatment choice on the other are interdependent. Rake (1961:205) observes among the Subanum of Mindano: Diagnosis-the decision of what 'name' to apply to an instance of 'being sick' is a critical cognitive step to illness by the Subanum. Thus, discourse on the native perception regarding illness is a necessity for understanding folk therapeutic behaviour. Based on their earlier experiences with illness, different people of different societies have different conception of health and illness. What is considered as being healthy is one society might not be considered healthy in another society (Mishra & Majhi: 2004).

3.2. Etiology

From time immemorial, human diseases and illnesses are said to have originated out of discrepancies related to religious beliefs, magical mysteries and supernatural dogmas and that too having a varieties of references in different cultural domain. Illnesses such as malaria have been conceptualized differently by different communities in traditional societies throughout the globe. The perception about the causes of malaria varies not only among different cultures but also among individuals depending on their socioeconomic background. Since few decades malaria has become a serious issue in country like India. The high burden populations are ethnic tribes living in the forested pockets of the states like Odisha, Jharkhand, Madhya Pradesh, Chhattisgarh and the North Eastern states which contribute bulk of morbidity and mortality due to malaria in the country.

From time immemorial human diseases are said to be originated due to discrepancies pertaining to religious beliefs, magic mysteries, and superstitious dogmas, that to have a variety of refreshes in different culture domain. Hence, we need to understand the agenesis of their culture before looking into their diseases in respective healing ointments.

The villagers were beliefs that the reasons of the diseases that the surrounding environment, seasonal vary and black magic. People mostly prefer to go *Gunia* treatment rather than medical practice. In village Tuniapali people mostly use herb product, local medicine and indigenous medical practices for medical treatment. Some villagers were unable to express the reason for different diseases and they don't know how to get treatment for a particular disease.

Role of women in decision making for health seeking behaviour is less and most of them are not participating in family decision making. Even in some house they not preferring for medical treatment for girls or ladies of that house. It was observed in field that around 61% of households are not allowing women to participate in decision making for health seeking treatment.

Tribal culture flourishes in the specific ecological function. The natural environment plays an important role in the formation of tribal culture in different eco-setting (Sarkar & Dasgupta, 2006). So the health seeking behaviour for dignosis and treatment of various diseases is related to the cognizance of their envirnment.

In most of cases, the villagers were not able say the cause of disease. Only some villagers are able to explain the right meaning of their diseases. According to cultural beliefs and view of the villagers and native health care specialists in Jhirdapali, the causes of illness are: Hereditary flow, Religious beliefs, Black magic, Man-made and Seasonal variation.

3.2.1. Hereditary Flow

There are few respondents who revel that few diseases like TB, neurological problems and headache are hereditary in nature. They think that some illness occurs due to genetic problem. Irrespective of communities all respondents believe that, if their parents or grandparents have any diseases then they also have the same disease and their children may face same diseases.

3.2.2. Religious Beliefs

The tribal people have a strong belief that the supernatural being may bring any diseases to them if it agree with their day to day activities. Wrath of the local deities and intrusion of evil spirit is considered as important reasons for various illnesses. As per their perception some religious beliefs like, mythological, supernatural, or spiritual aspects of a religion are the causes of illness. The doctrine of karma and re-birth still exists among tribals; they believe that evil deeds of parents also make the off spring suffer. If someone indulges in bad deeds, God become angry and inflict some diseases as punishment. There is a common belief found among all the tribal communities that death occurs only to the body of a person, but the soul (sue) always remains alive. The soul of their ancestors roams around their village. If any of them commit any mistake or violate social taboos they used to be punished by their ancestors.

The effect of evil eye is considered as one of the important reason for illness. There are some male and female in the village, who poses such evil eye. The role of evil eye in causing disease is very common in study area. It is believed that some individuals cast evil spell on others just by looking at them. Some do it because of jealous of others and desire to possess what other have. Children are believed to be particularly susceptible to the effects of the evil eye.

3.2.3. Black Magic (Sorcery)

Illness is believed to be caused by human agents through magical means. These categories are divided according to the type of causative agents recognized by tribals. Sorcery is a magical practice and it plays an essential role in the beliefs of the natives as main cause of illness. This act is performed by magicians (*Gunia/Raolia*) upon some individuals to harm by acquiring body parts like hair, nails, etc. The effect of these magical as well as paranormal forces leads a man to become weak, later that resulting in body drying up.

3.2.4. Man-made

Tribals have various notions regarding the food habits as they think that taking more food causes stomach pain. New water in the beginning of rainy season may cause some illness like cold and cough. It is also believed that some kind of pulses high temperature in the body, potato, mulling, and sheep meat create cold in the body. Excessive use of local alcohol (*Handia*) may cause for the bad health and create stomach pain.

3.2.5. Seasonal Vary

Certain diseases are found to be caused due to fluctuation of temperature and flow of wind. Prickle is believed to be an epidemic, which occurs by the flow of wind and rise of temperature in rainy season. A disease may be attributed to one cause on one occasion and to another cause on other occasion. Due deep forest and Basudihi dam is the main cause for many diseases, like Malaria, jaundice, diarrhea etc.

Chapter- IV

Health Seeking Behaviour

Indigenous people perhaps everywhere consider ritual remedies for diseases caused by supernatural agents, and counter magic for those caused by witchcraft and sorcery practices (Baily, 1991). When patient suffers from certain chronic diseases like T.B, stomach pain, high fever is believed to have caused for bad deeds in past life. Then, the patient suffering from those diseases goes for *Raolia* for offering rituals. The *pujari* offers some flower, coconuts, fruits etc, pray God and Goddesses to cure the patient. When a patient suffers from high fever, the villagers believe it as a course of Goddess Bolanimaa. As a remedy they used to visit the *pujari/Raolia/Gunia* and perform some *puja* as per their advice. In order to appease the village deity and ancestors they used sacrifice hen/goat and also offer some feast to villagers. Sometimes they take something from the *gunia* and consume it or tie it up. Their healing methods used to be influenced by certain factors like age, sex, source of earning, severity of diseases etc.

The diseases caused by natural factors like environment, food and behaviour the traditional herbal remedies are considered to be appropriate as it has been observed among many different communities (Gould & Pigg). The village medicine man of Jhirdapali panchayat visits the patient's house when he gets call from him. The medicine man diagnosis diseases and provide some medicine. Some time he takes his charges as monetary or some as kind.

The tribals of this area practices both modern medicines and traditional practices for treatment of diseases. Now-a-days they are willing to avail modern medical facilities due to non-available of traditional practices of medical care. They also have developed a faith on modern medicines and injections. The tribal villagers went to S.Balang CHC and Bonaigharh hospital for their health treatment. The local quack also provides better health treatment on which most of villagers depend.

4.1. Health Care Practitioner and Their Therapy

Since the beginning of the civilization, mankind has always been able to find some medicines in the nature around them to cure diseases. The early healing treatments were derived from the surrounding environment of the human, who were forest dwellers. They made use of plants, animals and other substances naturally available to them to treat illness (Sharma, et. al, 2006). Complex health care system of the simple societies evolved based on deep observation of the nature and environment. The medical system in simple societies is structured on the lines of herbal and psychometric treatment. The healing practices include a touch of mysticism, supernatural and magic, resulting specific magic-religious rites etc.

In Jhirdaplai panchayat it is found that apart from government and private hospitals there are four categories of health practitioner who deal with various health problems in providing health care facilities to the tribal communities. The health practitioners are *Kabiraj* (village medicine man), *Pujari* (priest), Quack, and *Gunia* (Shaman). The practitioners have different type of specialization, which is acquired from their parental generation and trough personal practices. The different healing care practices by the traditional practitioner are described below.

4.1.1. *Kabiraj*

Kabiraj also known as village medicine man, they provide some herbal medicines for all short common diseases. *Kabiraj* also reveals some interesting procedure for the diagnosis of the disease. *Kabiraj* of this village provides medicines for malaria, jaundice, stomach pain, joint pain etc. He used to go to forest and collect some fruits and roots of the trees and prepare some medicines as per his knowledge.

4.1.2. Quack

He prescribe some modern medicine for diseases, they don't have any medical certificate and don't have any authorized permission. Quack also provides door to door services to the patient. It was observed that most of the villagers depend on quack. The government

hospital is far away from village and don't have proper communication to reach over government medical.

4.1.3. *Gunia*

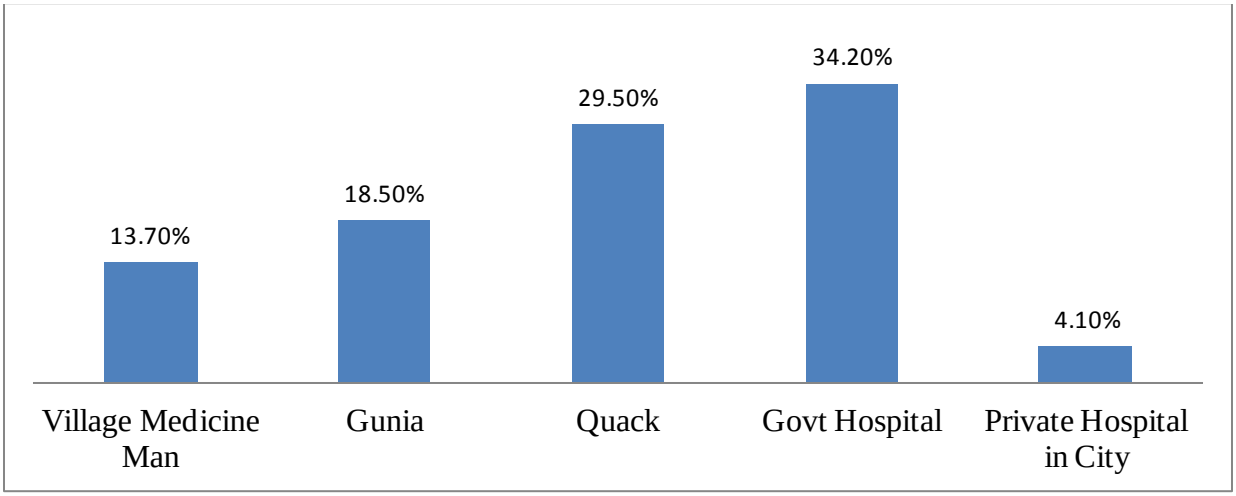
Gunia is priest cum shaman. This position is not hereditary and it can be achieved by mastering the spell and certain techniques of treatment. As a priest, they worship some god and goddess in home like MaaTarini, Kantha Mahapuru, Bolanimaa etc. Sometimes they take the patient to the village deity and sacrifice some animals. They also sometime provide treatment for Malaria, headache and fever etc.

4.1.4. *Pujari*

Pujari is popularly known as priest. He worship in village temples and also visit the houses on demand to perform some puja. Though villagers visit him at the time of any illness but he does not work as medicine man or like *gunia*. Only in few cases villagers used to bring their kids if they suffer any kind of evil eye. *Pujari* used to do some mantra (*jhada phunka*) and tries to cure the patient.

The chart no 4.1 reveals that a change has observed in relating to access to health care facilities. Around 34.20% sample households revel that they are visiting government doctors/hospitals during any illness. Around 29.5% households are relying on quack. Still 18.5% households are visiting *gunia* in any kind of disease. If they failed there then they may visit to village quack or village medicine man. Though the village medicine men are losing their importance due to impact of modern medicine, around 13.7% households revels that for any disease they are still visiting the village medicine men. The importance of visiting private clinic is very less. Due to low economic status only 4.1 % households revel that they are visiting private clinic. Those who are visiting private clinics mentioned that if the disease is so sever or if any earning person at house suffers then they give importance to visit private clinic (Chart No. 4.1).

Figure No. 4.1: Treatment Approaches to Different Medical System

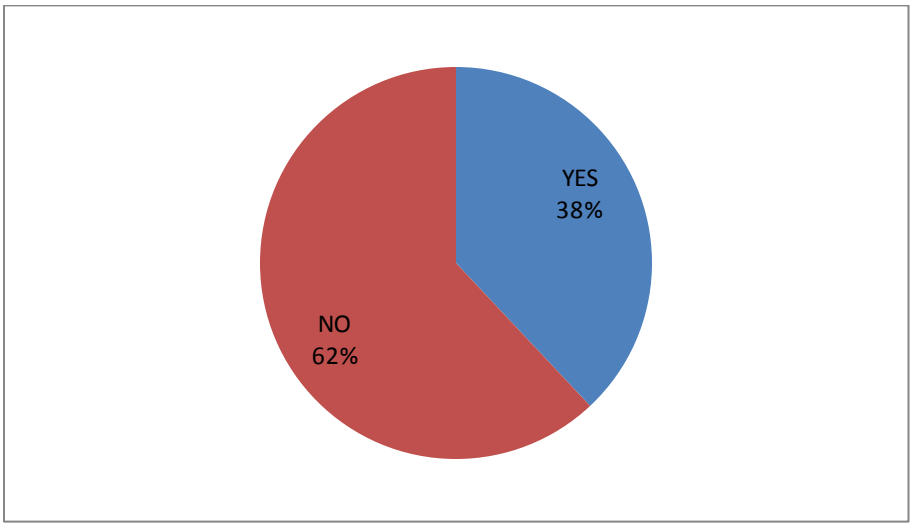


Source: Survey Data

4.2. Illness Behaviour and Decision Making Process

The member of the village thinks that illness behaviour is deviant from the normally accepted behaviour. This behaviour is highly influenced by the visibility and reconcilability of deviant and symptoms. The father of the person who suffers from illness and head of the household plays a key role in the process of decision making and seeking appropriate medical care. After identifying problems of ill health in case of children, the head of the household either used to decide the source of treatment on its own or sometimes consult with family members. The data from the field revels that only in case of 38% households the head of the households consult with other family members before taking any decisions (Chart No.4.2). As a process of consultation the head of the house hold first discuss with the family members then if required with relatives and then with neighbours and friends. Sometimes they used to consult with some villagers who suffered from this kind of diseases. It was observed during field works that the villagers who used to visit *kabiraj* or *gunia* if found the disease is not cured used to visit the village quack as next source of treatment. If the quack failed to recognize the disease and unable to diagnose properly then they visit the S.Balang CHC, which is 5 KM away from the locality (Chart No.4.2).

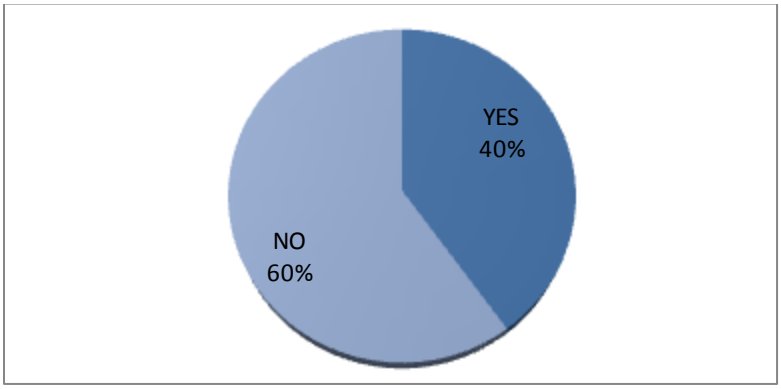
Chart No. 4.2: Consulted Within Family Members before Taking Health Treatment



Source: Survey Data

It also observed that if the father or head of the house is dead, then mother plays an important role for decision making in treatment. And if the head of house is ill then all family member stakes decision for treatment. If the ladies of the house are earning person then it also matters a lot in decision making. If a child of a family is ill then father's role is very important in decision making for treatment. It was observed in the field that around 40% women used to be consulted by their male counterpart while taking any decision relating to the treatment (Table No. 4.3).

Chart No. 4.3: Women Participation in Decision Making Process for Health



Source: Survey Data

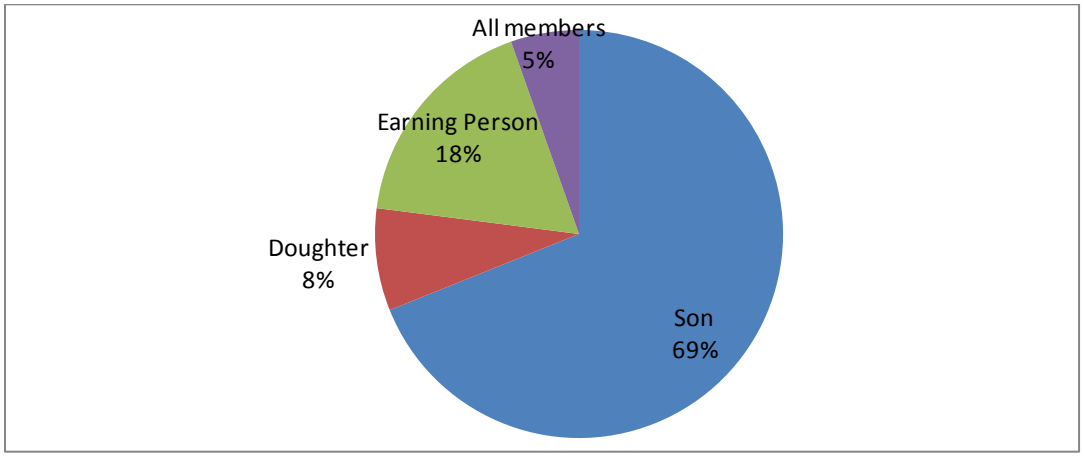
Illness behaviour does not end with the perception of the symptoms. The final phase of illness behaviour is the phase of cure seeking and it would be possible in different paths. Various factors like age, sex, education, chronic diseases, social & economic importance of the patient in the family, working season, duration of treatment, modern medical facilities, beliefs regarding the cause of diseases, previous experience effect of the path that people choose to seek health care.

4.2.1. Age

Age plays a significant role for perceiving symptoms and health care. Among the villagers, it was seen that younger person are more concerned about observing the deviation in their normal health condition. In contrast, the old men do not give much attention towards such deviation. The elders have shown greater faith in the traditional medicine, but the younger are going for modern health care facility. More awareness, education and anganwadi workers help village people to go for modern treatment.

In decision making process relating to health seeking treatment is observed that tribals give more importance to health of their children and they give much importance to the new born children then other due to emotional attachments. In some families they give more preference to boy child rather than girl child, they think that boy children will helpful for them in their old age (Table No. 4.4).

Chart No. 4.4: Community Preference While Seeking Treatments



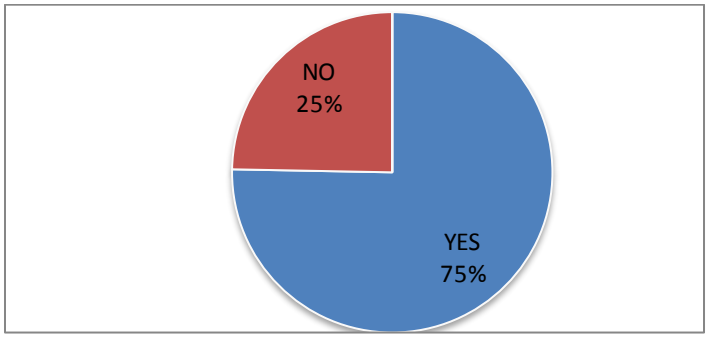
Source: Survey Data

4.2.2. Sex

The villagers are following patrilineal decent, for any illness, they give more importance for the health of a son rather than daughter. They think that a daughter will go to her father-in-law house after marriage, where as a son will take care of them at time of their old age and will inherit their name and perform their *sradha*. Women are reluctant to reveal their symptoms to family members because it puts them with unnecessary burden. In some serious cases they do not inform the problem even to their husband, because they don't want to give tension to their family members. In some households they give preference to female if they are considered as earned member. The data collected from the field reveals that around 69% of households give first preference towards male child rather than female child (Chart No. 4.4).

Sex of the practitioners also influences the source of taking treatment in the case of village. The villagers are ready to walk for a long distance to meet female practitioners. They maintain the same distance from both the male traditional and modern health providers. Tribal women feel shy to reveal their disease to male private practitioners and to folk healer. In the study area there has no female medical practitioner who is dealing with female disease. So, they prefer to S.Balang CHC or Bonai medical, which is far from their village. Some time they get medicines from Ashadidi or Anganwadi centre which helps them a lot. Most of women prefer to go for home based treatment, which may occurs very risk/harmful for them. In general it was observed in the field that around 75% households prefer to take home based medicine first (Chart No. 4.5).

Chart No. 4.5: Preference towards Home Based Treatment



Source: Survey Data

4.2.3. Education

Many villagers are illiterate or just primary education, some new generation villagers who have formal education shown knowledge about some diseases like tuberculosis, malaria and jaundice etc. People who are educated accept the modern medicine more readily than those who have no education. Some group of educated women started their own Self Help Groups (SHGs) for self- reliance. Through the SHGs they also contribute financially for their children education. The SHG members are giving more preference to modern medicine and prefer to hospital if they have any sickness or disease. It was observed in the field that around 60% households who believe on *gunia* are illiterate or just having primary education. Around 52% highly educated people are preferring quack or government doctor. Only 10% highly educated people are visiting *gunia* for treatment (Table No. 4.1). The above analysis reflects that education plays a major role in health seeking behaviour.

Table No.4.1: Preference of Treatment on the Basis of Qualification

Education	Treatment Approach					
	Quack	Gunia	Village Medicine Man	Govt. Doctor	Total	Percentage
Illiterate	21	21	5	3	50	33.78
Primary	9	9	5	8	37	25
Upper Primary	7	17	2	5	31	20.94
Above Matriculation	13	3	7	2	29	19.59
Total	50 (33.78%)	50 (33.78)	19 (12.83%)	18 (12.16%)	148	100

Source: Survey Data

Villager's strong faith on religious practices and gunia is being observed in few cases.

Case 1

Dropati Patra, a 65 years lady residing in Chandrapur village with her family. Her husband died last year due to malaria. All of sudden he felt pain in stomach. Due to their stong faith on *gunia* and other religious activities they visited a *gunia* near by their village and did some sacrifice near village deity. Though, S.Boland CHC is just 3 KM from their home they had not visited due to lack of awareness and illiteracy. After 3 days of severe pain the patient died. Though at last they were advised by the village medicine man to take him to hospital, there was no time.

Case 2

Tapaswini Sahu a 45 years widow and illiterate staying in Mardihi village. He lost her son due to malaria just 2 years back. He was very healthy. All of sudden he felt sever body pain and was taken to village medicine man. Though, village medicine man had given some medicine in suspense of malaria, he was not cured. After 3 days he was taken to a *gunia* near by their village. *Gunia* claimed that somebody has done some black magic on him and as per his advice they performed some puja and sacrificed a goat near village deity. However, all these things failed to save his life. But still she has strong faith on *gunia* and their treatment. Her illiteracy kept her in black to rely on superstition.

4.2.4. Economic Condition

The poor financial condition is another important factor, which makes most of the villagers vulnerable for taking health care. They discontinue the use of modern medicine which leads to fatal situation. Even for severe and chronic diseases, they do not visit doctors due to their poor financial status. They also think that if they visit a doctor, they will lose their work. All most all the villagers revel that they are facing the financial crisis over choosing the source of treatment. They never like to take hospitalization if the diseases are not so sever. If a patient who is considered as major earning source for the family used to be given first preference in treatment. In such case they used to go for Quack or private clinics in city for quick treatment. However, their adoption to treatment varies based on the earning season.

The members of the family whose economic contribution to the family are quite significant take longer time to assume the sick role, as their adoption of sick role will affect their family. Usually in the case of man and women who belong to families of poor economic status, the disavowal of sick role was naturally for a greater period. Most of the time they discontinue the use of modern medicine, which leads to fatal situation. Even for severe disease, they do not visit doctor due to their poor financial state. They also think that if they visit a doctor, they will lose their work.

Case 3

Nilamani Kisan was a 40 year old and lived with his family of six members. He was working as a wage laborer and sole bread earner of the family. Around one year back, one day suddenly he developed severe fever with shivering and vomiting. But he did not go for any treatment because he thought that it would be cured automatically. Next day morning there was no fever. But again after 2days he suffered from fever. At that time he thought it was because of hard work and thought to stop going work. As he was the sole bread earner of the family he could not afford to lose wages and so continued to go for work. The fever continued for one month and the symptoms became severe. Even then he felt that these symptoms were minor and a result of his hard work. When is wife suggested to go for treatment but he did not take a serious note of it and continued to go for work. After a while the fever became severe and he became very weak and incapable of doing any work. This was when he was taken to RMP (Registered medical Practitioner) who diagnosed him for malaria and directed him to the public health facility at Sarsara Balang. As he expressed his inability to afford this treatment when told about the possible cost, since he did not have any one to support him financially. Thus in this case the adoption of sick role and taking up treatment was greatly delayed because of economic compulsion.

Case 4

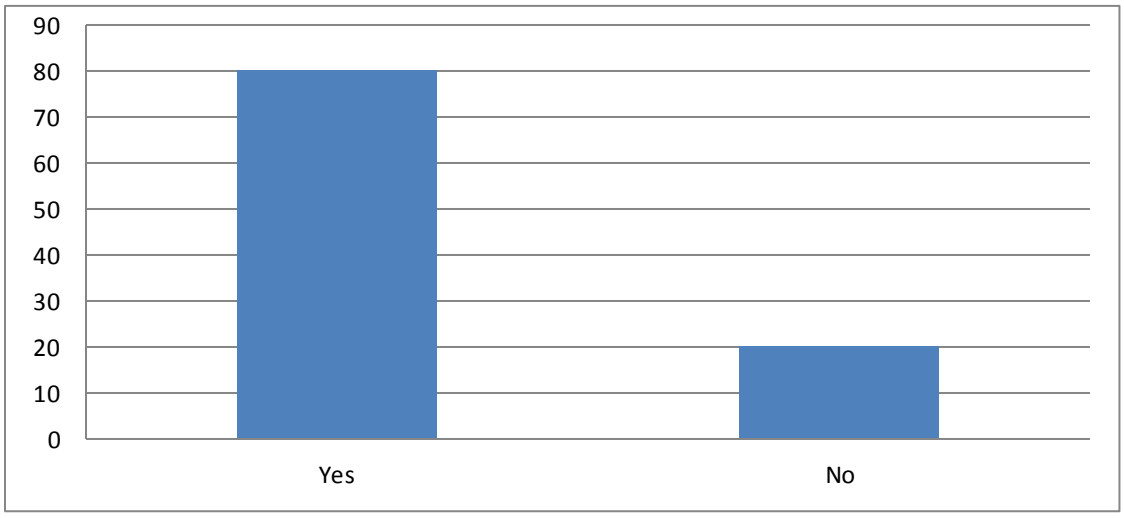
Chumki Munda, a 15 years old girl residing in Basudihi village. Since 5 years she is behaving in a different way. She used to beat all her family members due to her ill mental health. Her parents did lots of *puja* for her. Her family member consulted the

village medicine man first. Thereafter they took her to a *gunia* assuming that she is being cursed by some black magic. As per the advice of the *gunia* they sacrificed a hen and performed some puja near village deity. For the last one year they are taking her to the same *gunia* in a routine basis. Even some time they have consulted with a quack staying in his village. Though some of their relatives have advice them to take her to Rourkela hospital, they have not taken due to financial crisis. They are leaving with a hope that God will cure her one day. If God does not want she will be not cured.

If a person suffers from illness during cultivation and harvesting season he ignores it, because if he/she seeks for treatment he/she will lose his work and later suffer from lack of food. If duration of treatment takes long time the villagers do not like to choose that treatment because most of villagers are agriculture laborers. At the time of discussion, it was observed that around 40% households have borrowed money from various sources for their treatment. Most of them (70%) have borrowed from local money lenders.

Chart below shows that maximum households (81%) affected by sickness and it also effect on their income and food (Chart No. 4.6).

Figure No.4.6: Villagers' Perception towards the Effect of Sickness on Household Income



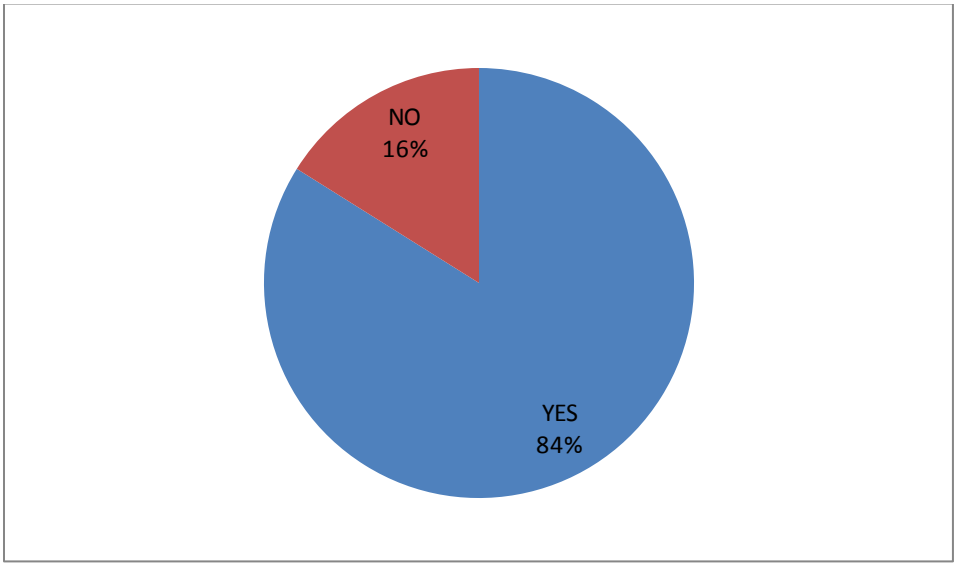
Source: Survey Data

4.2.5. Social Support

Social support is an important aspect that influences a patient's psychological condition and helps for speedy recovery. In the village an ill person gets considerable social support from the family members depending on the social status. It was observed that the young and potential workers in the family are given more social support then the aged and women. Social support is also extend from friends, relatives and neighbors to sick person. They advise the patient regarding care support from the others apart from the family members is limited in the case of illness caused due to the breach of taboo or sorcery. In such case it is thought that the patient is suffering because of his/her bad deeds. In case of sorcery of sympathy or support is given to a sick person. Sometime village chief, friends and neighbors also give suggestion for treatment and they also provide some financial and non-financial support to the patient family.

The chart below shows that around 84% of villagers took advice from their friends, neighbor, relatives etc for treatment at the time of requirement, while 16% mentioned that they never consult anybody apart from their family members (Table No. 4.7).

Chart No. 4.7: Taking Advice from others for Health Treatment



Source: Survey Data

4.2.6. Severity of Diseases

When people perceive a disease is severe they seek treatment immediately. Generally the villagers from very poor economic back ground give preference to traditional medicine. If the traditional medical system fails to cure the disease they seek for modern health care. If earning person accompany to the patient then that family lose some around Rs600/- for one time sickness.

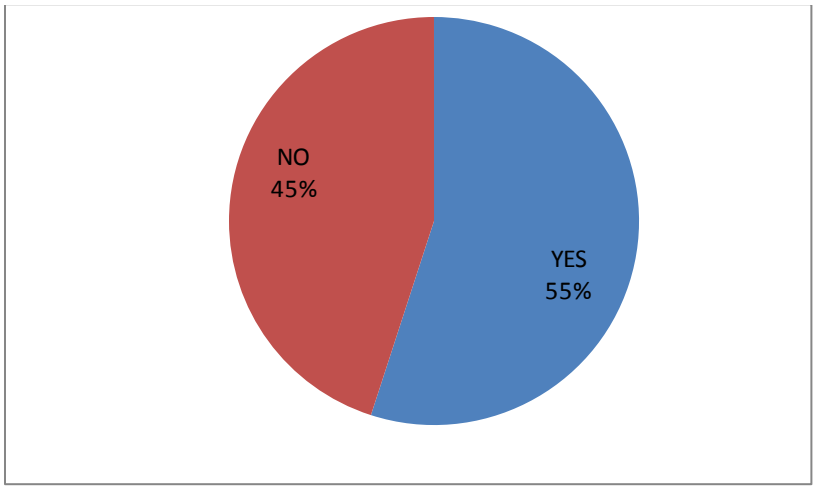
4.2.7. Previous Experiences

The previous experiences with any particular medical system lead the villagers to either accept or reject that particular medical system. This was noticed among the tribals that when the symptoms of any diseases the villagers do not go to any ethno-medical practitioner. They bring medicine from the quack, local medicine man or herbalist. Successful treatment of kin for similar diseases also mounts the way for opting treatment from modern medical system. Most of villagers take suggestion for treatment from their neighbors or relatives.

4.2.8. The Quality of Treatment

The quality of treatment is a major factor for determining the utilization of modern medical system. It is observed that when the traditional medical practitioner fails, the villagers prefer to visit private hospital or clinic rather than government hospital. They feel that most of the doctors in government hospital work in their own private clinic. It is common notion that the medicines prescribed in their own private clinic are far more effective than those prescribed in government hospital. Thus, people prefer to take more time to be completely cured, which is a big difficulty for the poor people of the village. During our field visit it was observed that the irregularity of the doctor and poor health care facilities have discouraged most of the villagers to visit the CHC. Around 45% households revel that they are not happy with the existing health care facilities available in their locality (Chart No. 4.8).

Chart No. 4.8: Satisfied With the Existing Health Care Facilities



Source: Survey Data

Chapter- V
Conclusion

The concept of health, illness, etiology and health seeking behaviour show the complexity of the tribals medical system in Jhirdapali panchayat. Their traditional medical system of late has come in dispute with the modern medical system. The villagers' perception regarding sickness, illness and disease to a great extent has still traditional. The cause of illness and healing system are found to be associated with the magico-religious beliefs. Along with herbal treatment, magico-religious practices are still occupying a significant position in their indigenous methods of treatment. In the context of decision making process head of the household play a dominant role. Though, mother takes the decision in the absence of counter person but the dominance of male in the case of health seeking is still prevailing. The analysis of the case studies and observations have shown the factor like age, sex, education of the patient, types of illness, severity of diseases, health care facility, beliefs regarding the cause of diseases and previous experiences effect selection of different ways of treatment. It is shown that lake of adequate modern health care facilities keep people away from modern medical care. Finally, it can be concluded that villagers responses to illness behaviour is guided and conditioned by their culture.

5.1. Limitation

Time limit for conducting the study is considered as major limitation of the study. The study was conducted during the month of December, which is considered as month of harvesting. During that time it was difficult to get villagers free. In order to extract the information regarding illness it is required to spend one year in field. But due to other academic activities it was not possible to spend much time in field. Another major constrain was lack of proper communication facilities. Language problem was faced while interacting with old people. Most of the old tribal people are not in a position to speak any other language except their local language.

5.2. Scope of the Study

A further study can be conducted to understand why the tribal communities are still following the traditional health practices. Why their acceptance to modern health care facilities is very slow.

5.3. Suggestions

i. Proper communication facilities should be developed
ii. Health centre should be established near to their village.
iii. Proper health care facilities should be provided at local area.
iv. Health awareness should be created in rural area.
v. Proper health education should be given to the villagers.
vi. Government should extended support to local herbal medicine practitioners.
vii. Government should provide health training to local quack.
viii. Panchayat should take care the local environment to avoid the spread of mosquitoes.
ix. A mobile health unit should be introduced to take care of villager's need.

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Appendix

HEALTH AND HEALTH SEEKING BEHAVIOR AMONG THE TRIBAL: A CASE STUDY IN SUNDARGARH DISTRICT OF ODISHA

Section 1
DEMOGRAPHIC INFORMATION

1.1 Head of the Household (HH): _____

1.2 Name of the Respondent: _____

1.3 Respondent's Relation with HH: _____

1.4 Sex: _____ (1.Male, 2. Female)

1.5 Marital status: _____ (1-Married, 2- Unmarried, 3-Divorce, 4-Widow/Widower)

1.6 Educational qualification: _____

1.7 Caste: _____ (1-SC, 2- ST, 3- OBC, 4- General)

1.8 Name of Sub caste/Tribe: _____ (1- Munda, 2- Gond, 3- Kisan, 4- Oraon, 5-Bhumij)

1.9 Religion:_____ (1- Hindu, 2-Muslim, 3- Christian,)

1.10 Hamlet _____b. Revenue village_____ c. Gram Panchayat_____, d.Tahsil_____, e. District_____

1.11 Main source of livelihoods: _____ (1-Service, 2- Own-cultivator, 3-Farm-labour, 4-Non-farm labour)

1.12 Number of family members: _____

1.13 Land holding: _____ (1.Yes, 2.No) (Acres) _____.

1.14 BPL card holder: _____ (1-Yes, 2.-No)

1.15 Antyodaya card holder: _____ (1-Yes, 2- No)

1.16 Old age pensions anybody receiving at home: _____ (1-Yes, 2-No)

1.17 Have you received Indira Abasa: _____ (1-Yes, 2-No)

Section 2
HOUSEHOLD COMPOSITION

SR NO	Name of the person	Relation to HHH	Sex	Age	Marital status	Education (for above 5 year)	Occupation		Current monthly income	Any skill possessed
							Main	Subsidiary		

CODES: For relationships :(Father-1, Mother-2, Sister-3, Brother-4, Grandparents-5, Grandchildren-6, Cousin-7, Wife-8, Son-9, Daughter-10, Daughter in law-11, Son-in-law-12, Others-13), **For education**: (Illiterate-1, lower-primary (class 1-4)-2, Upper Primary (class 5-7)-3, High school (class 8-9)-4, Matriculation-5, Intermediate-6, Gradutate-7, Above graduate-8), **For occupation**: (Self employed-1, Employed in Govt sector-2, Employed in private sector-3, Agricultural labor-4, Industrial labor-5, Migrant labor-6, Daily wage labor-7)

Section 3
HOUSING, AGRICULTURE LAND AND OTHER AMENITIES
3.1 HOUSE STRUCTURE

Housing and other amenities		
House type	1-Pucca/ 2-Semi-Pucca/ 3-Kutcha/ 4-Hut/ 5-Temporary	
Sanitation	1-yes, 2-no	
Kitchen room	1-Separate/2-Attached	
Cow shed	1-Separate/2-Attached	
Main Cooking fuel	1- Wood, 2-charcoal,3-kerosine, 4-Cow dung, 5-Gas	
Main source Drinking water	1-Tube well, 2- open well, 3-stream, 4-pond	
Cow shed	1-yes, 2-no	

3. 2 LAND HOLDING PARTICULARS

Area (in Acres)				
Area Owned *	Area leased in	Area Leased out	Net sown area•	
			In	Out
* Area Owned = Total Area – Home Area Net sown area/Net operated area = Area Owned + Area leased in – Area leased out				

3.3 SOURCE OF IRRIGATION & ACRES

Source of Irrigation	Areas (Acres)		
	Kharif	Rabi	Total
Canal			
Tank			
Well			
Others			
Total			

3.4 CROPPING PATTERN, PRODUCTION AND RETURNS: (LAST YEAR)

Type of Crop	Acres		Investment		Production (Quintal/ Basket)		Sold		Value Received		Total Value received
	K	R	K	R	K	R	K	R	K	R	
Total											

3.5 SOURCES OF FAMILY INCOME

Sl. No.	Sources of work	Number of family members engaged	Nature of work		Annual income in rupees (Refer to Last production year)
			Continuous/ Seasonal	Duration of work, number of days	
1.	Agriculture				
2	Forest Resources				
3	Wage labour				

4	Employment (Govt.)				
5	Employment (Pvt.)				
6	Common Property Resources				
7	Business				
8	Fishery				
9	Goat rearing				
10	Sheep rearing				
11	Chicken/duck				
12	House rent				
13	Rents from other property/assets				
14	Horticulture				
15	Others (Specify)				
Total					

Section 4

HEALTH FACILITIES

4.1 Do you have any health center near to your Village? _____ (1-Yes, 2- No)

4.2 Do you get free medical services? _____ (1-Yes, 2- No)

4.3 Is there free distribution of medicine by GP during any epidemic__ (1-Yes, 2- No)

4.4 Do the health department visit and conduct health check-up frequently__(1-Yes, 2-No)

4.5 Is there any emergency facility available here? (1-Yes, 2- No)

4.6 Is there any doctor available in your hospital? (1. Yes, 2- No)

4.7 If yes, does the doctor stay here? (1. Yes, 2- No)

Section 5

HOUSEHOLDS THAT REPORTED DIFFERENT ILLNESSES EXPERIENCED (LAST ONE YEAR)

Sl. No.	Diseases	Yes/ No	Sl. No.	Diseases	Yes/no
1	Malaria		5	Cancer	
2	Diarrhoea		6	T. B	

3	Stomach Pain		7	Headache	
4	Infection		8	Other	

Section 6

HEALTH SEEKING RELATED QUESTION

6.1 Is there anybody suffer from any serious diseases in last one year? (1. Yes 2. No)

6.2 If yes, please mention details

Person	Sex (M/F)	Age	Name of Disease
Son (1)			
Daughter (2)			
Father (3)			
Mother (4)			
(5)			
(6)			
(7)			

6.3 Can you mention the reason for this disease? (Put Tick Marks)

a-Man made, b-Seasonal vary, c- Environmental Impact

d-Religious Beliefs, e- Hereditary Flow, f- Black Magic

6.4 Have you taken any treatment to cure these diseases? (1- Yes, 2- No)

6.5 If no, why? _____

6.6 If yes? Whom did you approach? (1- Village medicine man, 2- Gunia , 3- Govt. Doctor , 4- Quack, 5- Private clinic in city)

6.7 Mention the reason for visit the above said place.

a-Services are free of charge b- Health Center far away c- Near to home

d-No money to pay for services, e- Use herbs f- Other

6.8 Have you ever consulted within your family members before going to this place? (1. Yes, 2-No)

6.9 Do you involved ladies in the process of consultation within the family? (1. Yes 2. No)

6.10 Does anybody advise you to visit this place? (1. Yes, 2. No)

6.11 If yes, mention the relation with that person. (1- Friend, 2- Relative, 3- Village 4- man)

6.12 Had the patient cured there? (1-Yes, - No)

6.13 If no, have you consulted any alternative treatment further? (1.Yes 2. No)

Section 7

TREATMENT SEEKING BEHAVIOR

7.1 Where do you first go for treatment when you are sick?

1- Quack, 2- Herbalists, 3- *Gunia*, 4- Private Clinic, 5- Govt. Doctor.

7.2 When you have visited the Shaman/ Dhami/ Jhakri/ Priest, what he did?
1. Phukphak. 2. Worship 3. Sacrifice. 4. Other (Specify)
_____.

7.3 What factor influenced you to go there?

[1- Quality/Satisfaction, 2- Near to home, 3- Cheap, 4- Usual practice.5. Other (Specify)]

7.4 Are you satisfied with Health Worker/Doctors or with treatment? (1- Yes, 2- No)

7.5 What category of health facilities do you have? _____ (1-Govt. 2-Private)

7.6 If going to clinic, how far is the clinic from this village? _____ (1-Less than one hour , 2- 2-3 hours)

7.7 How do you get there? _____ (1-Tracking/walking, 2-Vehicle, 3-Other)

7.8 Does the sickness affect the Food behavior and Income of the household? ____
(1-Yes, 2- No)

7.9 Is it possible to access the health centre during the weekend or holidays? _____
(1. Yes, 2. No)

7.10 How do you manage with emergency cases here? _____ (1-Ambulance, 2-Private Transport, 3- Carry patient by bullock cart, 4- Other)

7.11 If you have a boy and a girl in your house and they are both sick, who do you take to the hospital first? _____ (1- Boy, 2- Girl)

7.12 Why did you choose a boy or a girl? _____

(s1-Boy are important, 2- Girls are important, 3- Boy will bring more money, 4-Girls will bring more money, 5-Boy will inherit me, 6- Boys will continue my family, 7- Other)

7.13 Has any member of the household been ill and could not be taken to the clinic? __ (1. Yes, 2- No)

7.14 Has any member of your household died in the last one year? ___ (1. Yes, 2. No)

7.15 If Yes, what was the cause of death? (1- Diarrhea, 2- Malaria, 3- Stomach pain, 4-Road accident, 5- Unknown, 6- Other s) _____

7.16 Who decides on how to use the money generated for the family? ____ (1-Father, 3- Mother, 3- All members of the household)

7.17 Is women are participating in decision making for health treatment? (1-Yes, 2- No)

Section 8

HEALTH CARE UTILIZATION & FINANCING (LAST ONE YEAR)

8.1 Has any member of your household been ill in the last 1 year? ____(1-Yes, 2- No)

8.2 If yes, how many members of your household were ill? _____

8.3 Where did the money you used to pay for the treatment come from? _____

(1- Other household member, 2-Neighbours, 3-Money lender, 4-Personal funds/savings, 5-Sold assets/property, 6- Pawned assets property, 7 Other

8.4 Do you have a Social Fund that you use when you need money to cover health care in this community? _____ (1-Yes, 2- No)

8.5 If Yes, how long have your community had the Social Fund? _____ (1) Less than 1year; (2) 1- 4years; (3) 5 - 9years; (4) More than 10 years

8.6 If Yes, how are contributions made into the social fund? ____ (1) Monetary contribution; (2) In kind contribution; (3) Both 1 & 2

8.7 If you have such social fund, have you or any member of you family used it before?____ (1) Yes (2) No

8.8 How helpful has this social fund been to you and your family in time of need? _____ (1) Not helpful at all; (2) Helpful somehow; (3) Helpful; (3) Very Helpful; (4) Don't know

8.9 Do you have health insurance? _____ (1- Yes, 2-No)